MEDDIC-MS SSI 2003 Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set
SSI Managed Care

Wisconsin Independent Care (*i*Care) Program

State of Wisconsin

Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

December 2004

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MEDDIC-MS SSI 2003 Data Book, Wisconsin Independent Care(iCare)Program, State of Wisconsin, Department of Health and Family Services, December 2004.

Introduction and Background

In its 2002 book, ***Leadership by Example: Coordinating Government Roles in Improving Health Care Quality***, the Institute of Medicine (IOM) called for standardized, accurate, real-time performance measures for health care, particularly for publicly-funded programs. For example, it recommended:

- Measures "derived from computerized data and public reporting of comparative quality information."
- "Providers should not be burdened with reporting the same patient-specific performance data more than once to the same government agency."
- "Finally, effective performance measurement demands real-time access to sufficient clinical detail and accurate data. By the time retrospective performance measures reach decision-makers, it is too late for them to be useful. The current health information environment is far too fragmented, technologically primitive, and overly dependent on paper medical records."

In addition to being central to effective public health policy, as described by the IOM, standardized performance measures are required by federal law for all state Medicaid managed care programs, including those serving special populations such as individuals with disabilities. Specifically, 42 CFR §438.240(c) requires that states monitor managed care organization (MCO) performance using standardized performance measures and that MCOs submit data necessary for the performance measures to operate. Wisconsin has implemented new quality improvement performance measure systems in its managed care programs.

MEDDIC-MS SSI is a subset of encounter data driven managed care performance measures called MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set). It is specifically designed for Wisconsin's Independent Care (*i*Care) program, which serves enrollees eligible for supplemental security income (SSI). Independent Care (*i*Care) is a managed care program operated by a private organization under a contract with the Wisconsin Department of Health and Family Services (DHFS). Use of MEDDIC-MS SSI is implemented for *i*Care under its contract with the DHFS.

In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS SSI for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS SSI

The ***Medicaid Encounter Data Driven Improvement Core Measure Set for SSI***, is the state-specified performance measurement system for Wisconsin's SSI managed care program known as Independent Care or *i*Care. It consists of two sets of measures; Targeted Performance Improvement Measures (TPIM), which focus on high priority areas identified by stakeholders and monitoring measures, most of which are utilization measures.

Operating features of the MEDDIC-MS SSI system include:

- ***Encounter data-driven measures:*** MEDDIC-MS SSI utilizes encounter data and other applicable State-controlled data sources eliminating the need for medical record review. This reduces data acquisition costs and eliminates errors caused by inaccurate patient-supplied history. Medical record review continues to be used for data validity audits, ambulatory quality of care audits, cases where augmentation of encounter data is desired and for special audit functions.
- ***DHFS data extraction, measure calculation and reporting:*** The Department of Health and Family Services (DHFS) extracts data for each measure and calculates performance on the measure through a third party data services vendor. This reduces errors and inconsistencies due to possible misinterpretation of reporting specifications. *i*Care does not report on performance measures. This allows more resources to be devoted to performance improvement initiatives and reduces administrative cost and complexity.
- ***Customer/vendor relationship:*** Traditional managed care performance measures allow managed care organizations to report their own performance. MEDDIC-MS SSI corrects this problem.
- ***Speed, relevance and trending:*** DHFS has the option to calculate measures as needed and in time frames other than traditional calendar year reporting.
- ***Accuracy:*** MEDDIC-MS SSI specifications use validated encounter data and, in some measures, other state-controlled data sources.
- ***Performance improvement goals:*** Performance goal setting is designed to first establish baseline levels using MEDDIC-MS SSI measures and then through a collaborative process, establish realistic intermediate goals for subsequent years to facilitate "ramping up" performance.

Complete technical specifications for the MEDDIC-MS and MEDDIC-MS SSI measure sets are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

The performance results on these measures for 2002 are available on the Wisconsin Medicaid Managed Care Website. To view these reports, please go to: http://www.dhfs.state.wi.us/medicaid7/providers/index.htm and scroll down to "Quality Reports."

Care Analysis Projects

Since 2001, the DHFS has implemented an innovative approach to performance improvement called Care Analysis Projects (CAP). Through CAP, recipient-specific health care needs are identified and the data about those needs are shared with *i*Care. In this way, the DHFS seeks to assist directly in quality improvement by allowing focused outreach to individuals with potential unmet care needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes.

MEDDIC-MS SSI and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS SSI allows accurate, rapid performance assessment.

Performance Improvement Projects

The *i*Care contract requires it to complete at least two performance improvement projects in each calendar year and submit reports about them to the DHFS annually. The projects encourage interventions for performance improvement on topics of importance to *i*Care enrollees.

Note on performance rates:
Some *i*Care enrollees are eligible for services under Medicare as well as the SSI program. As a result, some services may have been obtained under that program and may not be reflected in *i*Care encounter data. To prevent under-reporting of services provided by *i*Care, individuals eligible for Medicare have not been included in the denominators for measures reflecting services covered by Medicare. The narrative with each chart indicates which measures are affected.

Results on Clinical Performance Measures

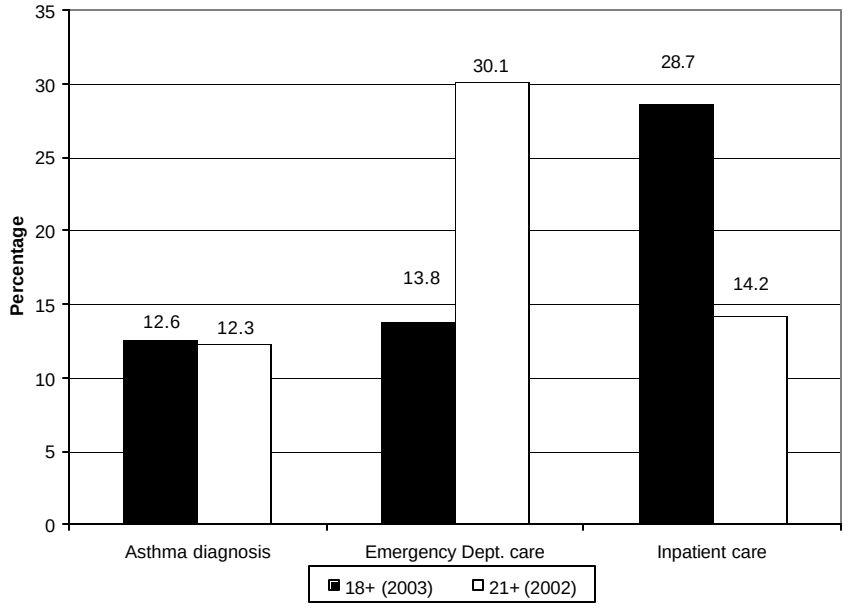
Asthma care

Monitoring measure

Asthma is a chronic respiratory condition affecting the lungs. People with asthma suffer episodes where airflow in and out of the lungs is reduced by constriction of the airways in the lungs and by excess mucous. Between 12 and 15 million Americans have asthma, including nearly 5 million children.

Episodes of asthma can be reduced with effective management, appropriate medication use and patient education. For these reasons, early diagnosis, patient/parent education and medical management are crucial to prevention of exacerbation and maintenance of good quality of life.

Asthma--Prevalence, ED care and Inpatient Care, (Medicaid Eligible Only), iCare, 2003 Compared to 2002



Note, however, that the age cohorts were changed from one year to the next due to very small numbers in the youngest age cohorts used for calculating results in 2002. For this reason, the 2003 data includes enrollees 18 years of age and over; the 2002 data is for enrollees 21 years of age and over. In the future, the measure will use the 18 and over age range.

Asthma prevalence among *i*Care enrollees age 18+ years of age was 12.6 percent in 2003; it was 12.3 percent among enrollees over age 21 in 2002. The rate of use of emergency department (ED) care by enrollees 18+ years of age was 13.8 percent; a substantial decrease from 2002 for enrollees over age 21. The rate of inpatient care was 28.7 percent for asthma among enrollees age 18+ years; in 2002, the inpatient care rate was 14.2 percent among enrollees over age 21.

This measure tracks services for individuals eligible for Medicaid only.

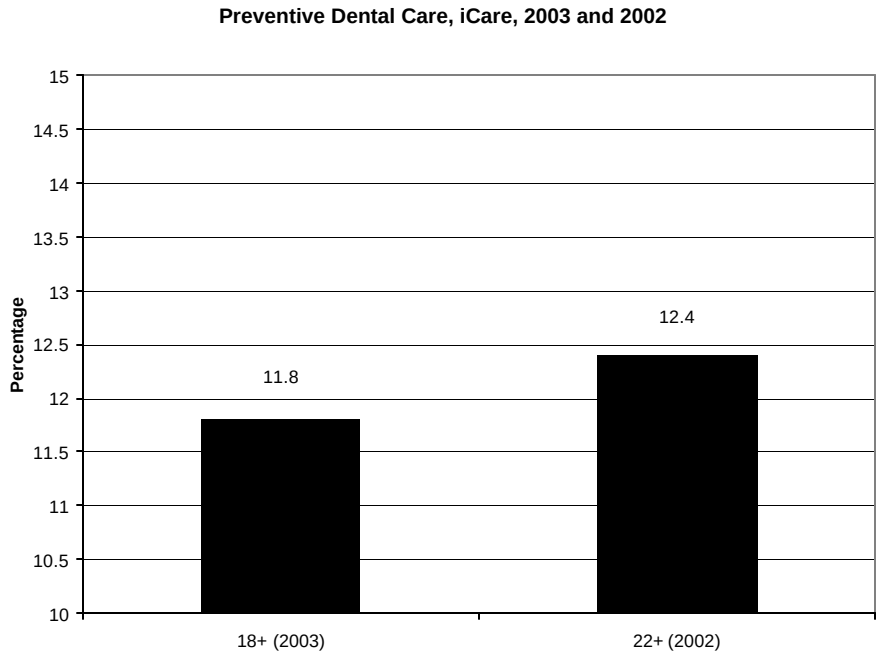
Dental (preventive) services

Targeted performance improvement measure

Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems.

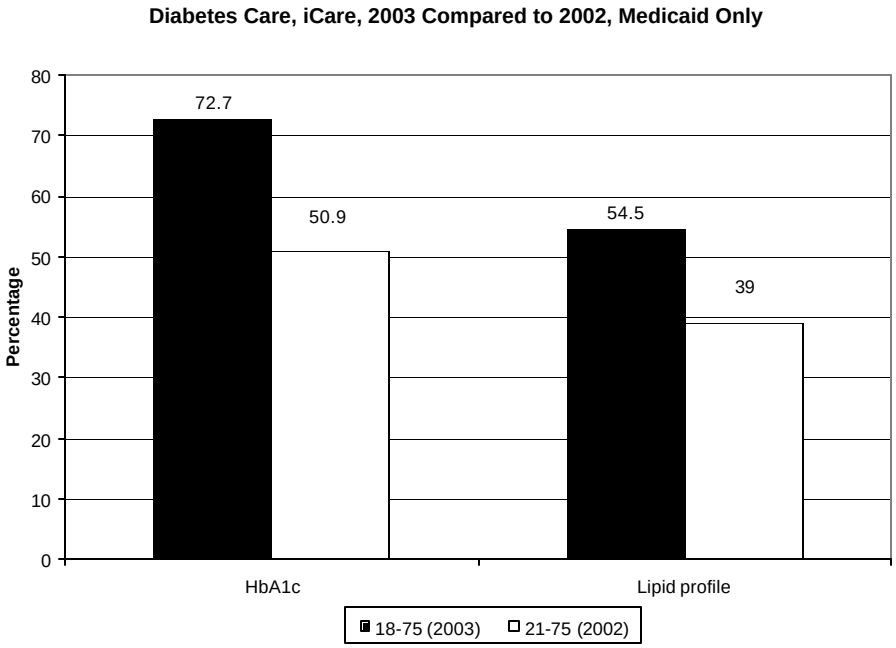
The measure technical specifications have been changed since the 2002 measurement cycle with respect to the age cohorts monitored in order to more accurately reflect the *i*Care population. In 2003 the measure age cohorts were changed from 15-21 and 22+ years to 18+ years.



In 2003, 11.8 percent of iCare enrollees age 18+ years had at least one dental care encounter where preventive services were provided. This is a slightly lower rate than 2002 when 12.4 percent of enrollees age 22 and older had such dental visits. Direct comparison should be made with caution due to the difference in the age cohorts.

Diabetes care

Targeted performance improvement measure



Diabetes mellitus is a chronic condition that can have devastating effects including heart disease, kidney damage and blindness.

The serious consequences of diabetes can be reduced or prevented with proper management.

Two important diabetes management tests are monitored in Wisconsin's performance measure system.

One test is the hemoglobin A1c (HbA1c), which is a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, which is a blood test that monitors the levels of "fats" (lipids) in the blood stream. Though these tests do not allow definitive assessment of quality of life for diabetic individuals nor of total quality of care for diabetes, they do allow assessment of key indicators of diabetic management.

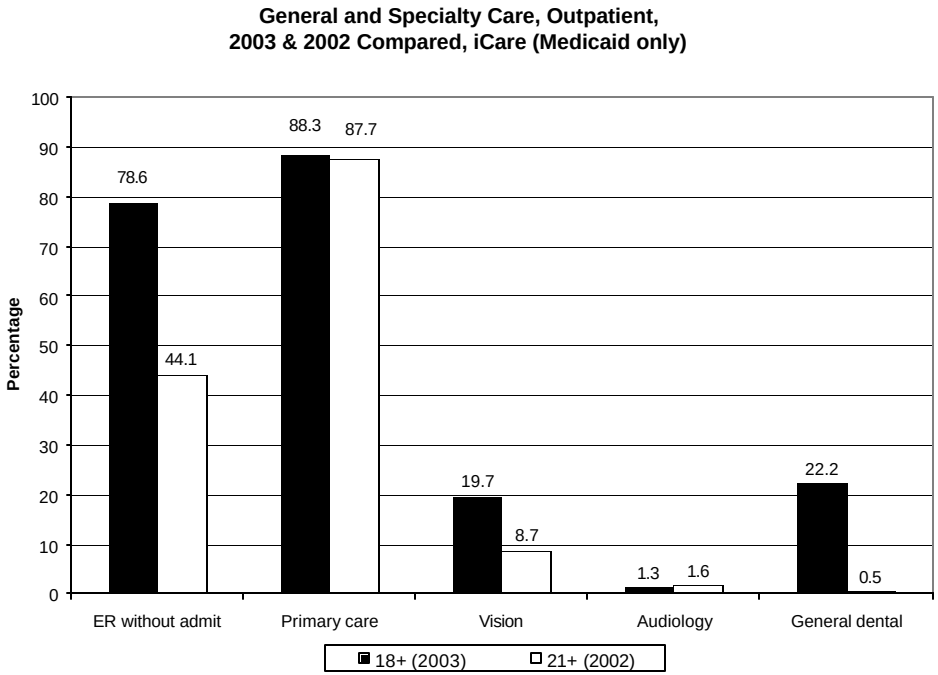
The measure technical specifications have been changed since the 2002 measurement cycle with respect to the age cohorts monitored in order to more accurately reflect the *i*Care population. In 2003 the measure age cohorts were changed from 15-20 and 21-75 years to 18-75 years. The youngest age cohort had too few enrollees in the denominator to show any values in 2002. Only the 21-75 year old age cohort is compared in this chart.

In 2002, the HbA1c test rates for enrollees age 21-75 was 50.9 percent. In 2003, the HbA1c rate increased to 72.7 percent for 18-75 year-olds. The rate for lipid profiles was 39 percent in 2002 (age 21-75) and 54.5 percent in 2003 (18-75 year-olds).

This measure tracks services for individual eligible for Medicaid only.

General and specialty care-outpatient

Monitoring measure



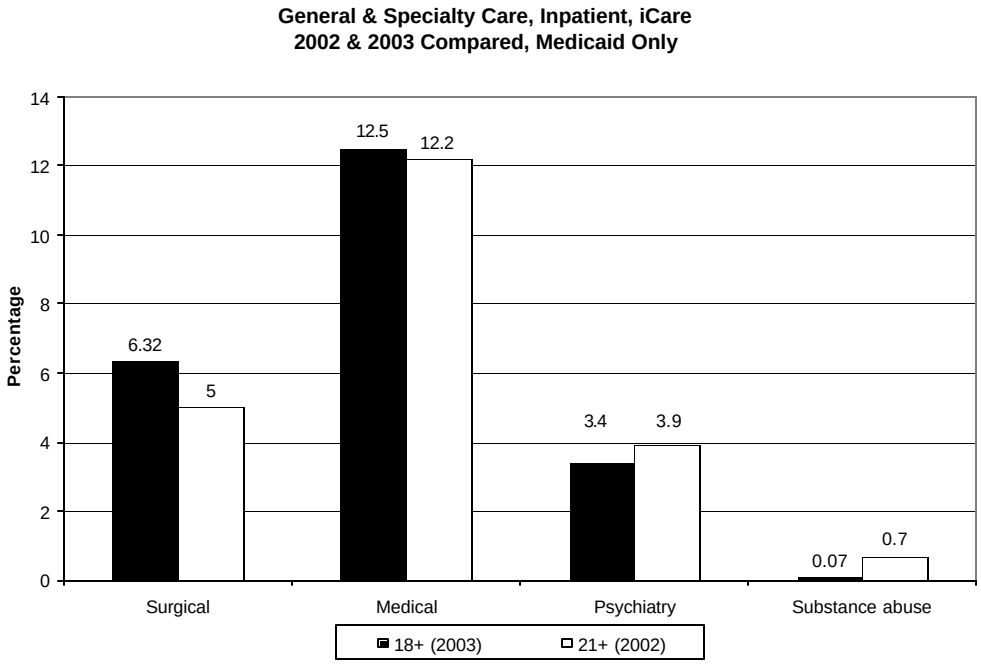
This measure assesses access to emergency care that does not result in subsequent hospitalization, access to primary care, vision care, audiology services and general dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of *i*Care enrollees had access to those services on at least one occasion during the look-back period. The chart displays the overall results for 2003, with comparative data for 2002. Note, however, that the age cohorts were changed from one year to the next due to very small numbers in the youngest age cohorts used for calculating results in 2002. For this reason, the 2003 data includes enrollees 18 years of age and over; the 2002 data is for enrollees 21 years of age and over. In the future, the measure will use the 18 and over age range. The measure includes enrollees that are eligible for Medicaid only-not Medicare also-in the denominator.

Nearly 8 in 10 enrollees had at least one emergency room visit that did not result in admission to the hospital in 2003, a substantial increase from 2002. Nearly nine out of ten enrollees had at least one primary care visit in each year. Vision care use increased and audiology care use remained stable. Access to general dental services increased substantially.

General and specialty care-inpatient

Monitoring measure



Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for many different conditions. For the purposes of the *i*Care performance monitoring program, four general categories of care are used: surgery, medical, psychiatric and substance abuse.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery. This data reflects utilization by Medicaid-eligible enrollees only.

The chart displays the overall results for 2003, with comparative data for 2002. Note, however, that the age cohorts were changed from one year to the next due to very small numbers in the youngest age cohorts used for calculating results in 2002. For this reason, the 2003 data includes enrollees 18 years of age and over; the 2002 data is for enrollees 21 years of age and over. In the future, the measure will use the 18 and over age range.

Utilization rates in each category were stable from 2002 to 2003.

Mammography (screening) and malignancy detection

Monitoring measure

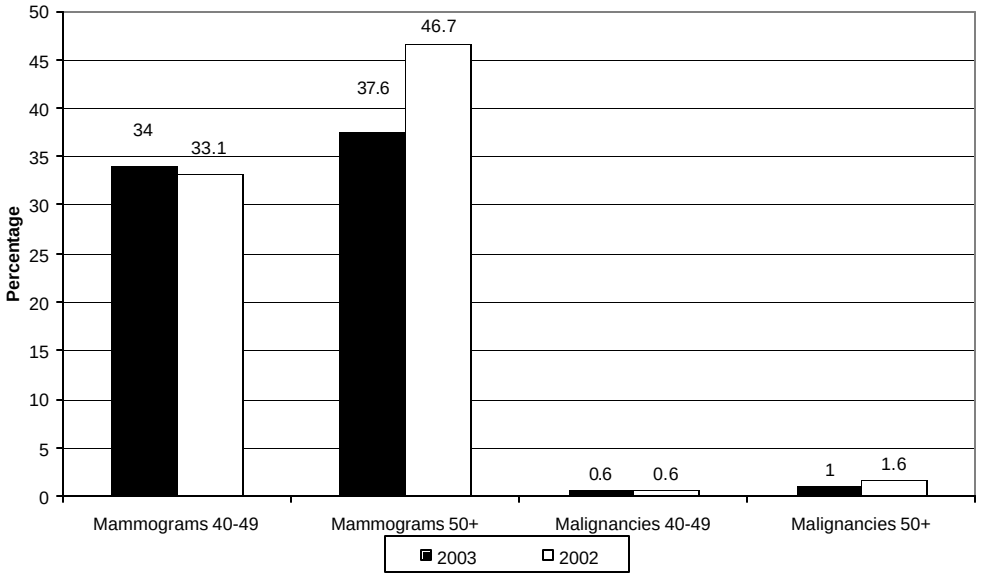
The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Early detection of breast cancer dramatically improves outcomes of treatment and long-term survival.

Mammography is recognized as a highly effective method for early detection of breast cancer.

Facilitating and tracking the provision of screening mammography is important for women served in the *i*Care program because of the benefits of early detection and treatment.

Mammography and Malignancies Detected, iCare, 2003 Compared to 2002, Medicaid only

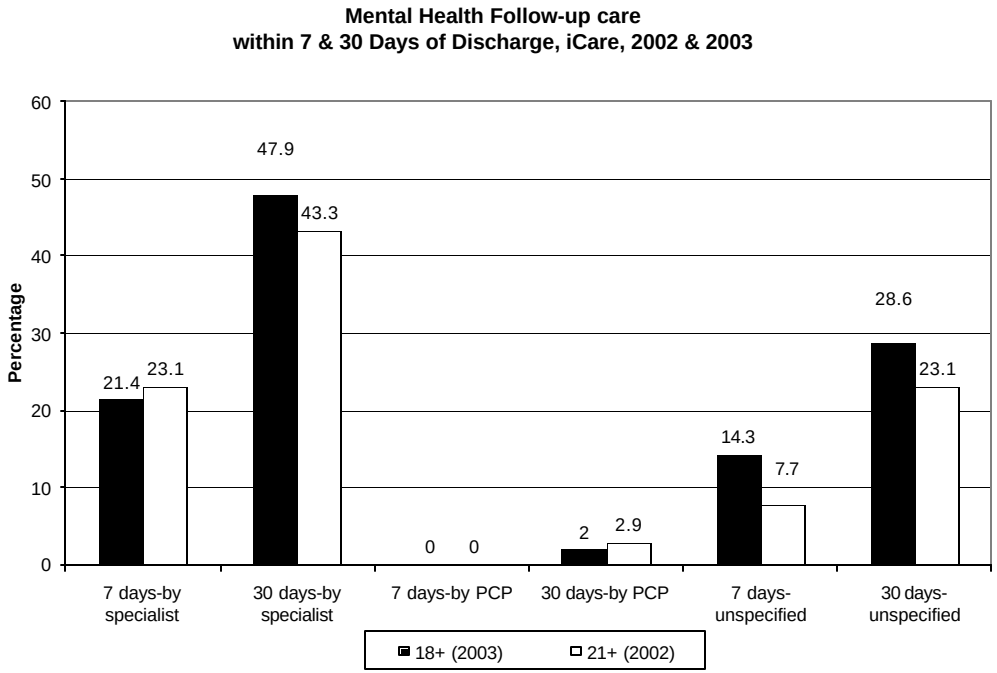


The screening mammography rate for women between the ages of 40 and 49 years was 34.0 percent in 2003, an increase from the 2002 rate of 33.1 percent. The malignancy detection rate remained unchanged from 2002 at 0.6 percent. For women over 50 years of age, the screening mammography rate decreased in 2003 to 37.6 percent from 46.7 percent in 2002. The malignancy detection rate for women over 50 years of age decreased slightly to 1.0 percent from the 2002 rate of 1.6 percent.

This measure tracks services for individual eligible for Medicaid only.

Mental health / substance abuse follow-up care within 7 and 30 days of inpatient discharge

Targeted Performance Improvement Measure



Research[1] has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.

This measure evaluates provision of follow-up care by both specialty care providers and primary care providers within 7 days of discharge and within 30 days of discharge from inpatient treatment. Since appropriate service codes appear on encounter records, but at times the provider type is not specified, the measure set includes these encounters in the category of "unspecified" to prevent underreporting.

The chart displays the overall results for 2003, with comparative data for 2002. Note, however, that the age cohorts were changed from one year to the next due to very small numbers in the youngest age cohorts used for calculating results in 2002. For this reason, the 2003 data includes enrollees 18 years of age and over; the 2002 data is for enrollees 21 years of age and over. In the future, the measure will use the 18 and over age range. Due to the differences in the age cohorts used, comparisons should be made with caution. Also, the chart reflects follow-up care for mental health diagnoses only, since the denominator for substance abuse services was too small to report accurately.

Most rates were stable from 2002 to 2003, though an increase occurred in specialist care within 30 days of discharge and small increases occurred in follow-up care provided within 7 days and 30 days of discharge by unspecified providers.

[1] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

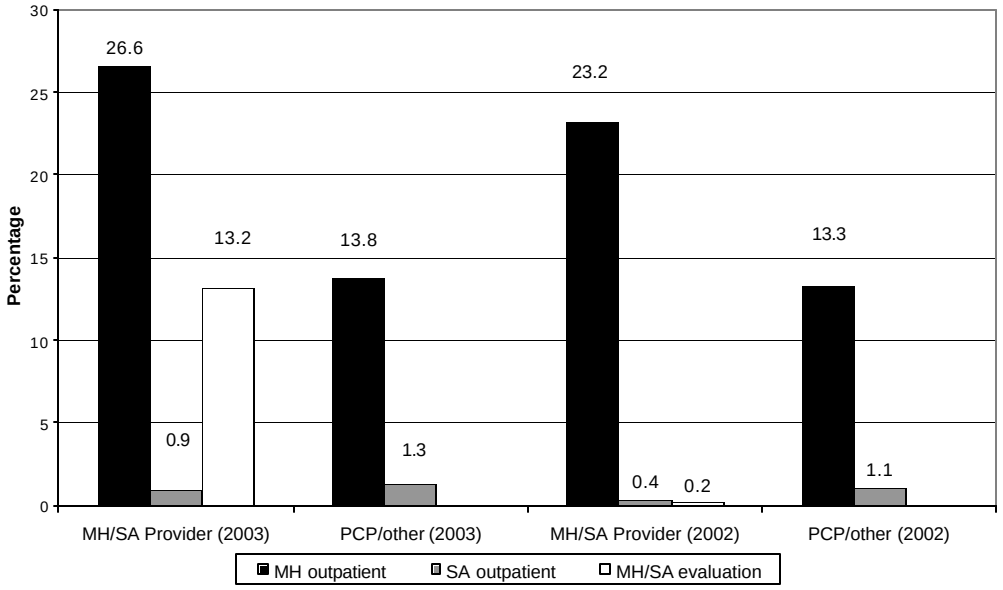
Mental health / substance abuse-evaluations and outpatient care

Monitoring measure

The possibility that access to mental health and substance abuse (MH/SA) evaluation and treatment services may be inappropriately restricted in the SSI managed care program is a concern. Monitoring the rate of evaluation and treatment services is useful to detect access trends.

Statewide data shows that psychiatric disorders are the second most prevalent affecting SSI program recipients, being diagnosed in 32 percent of the population. Substance abuse is the 12th most prevalent diagnosis in this population. In some instances, the two diagnoses occur together. Thus, access to mental health and substance abuse care is very important.

Mental Health & Substance Abuse Evaluations and Day/outpatient treatment, by Provider Type, iCare, Medicaid only 2002 & 2003



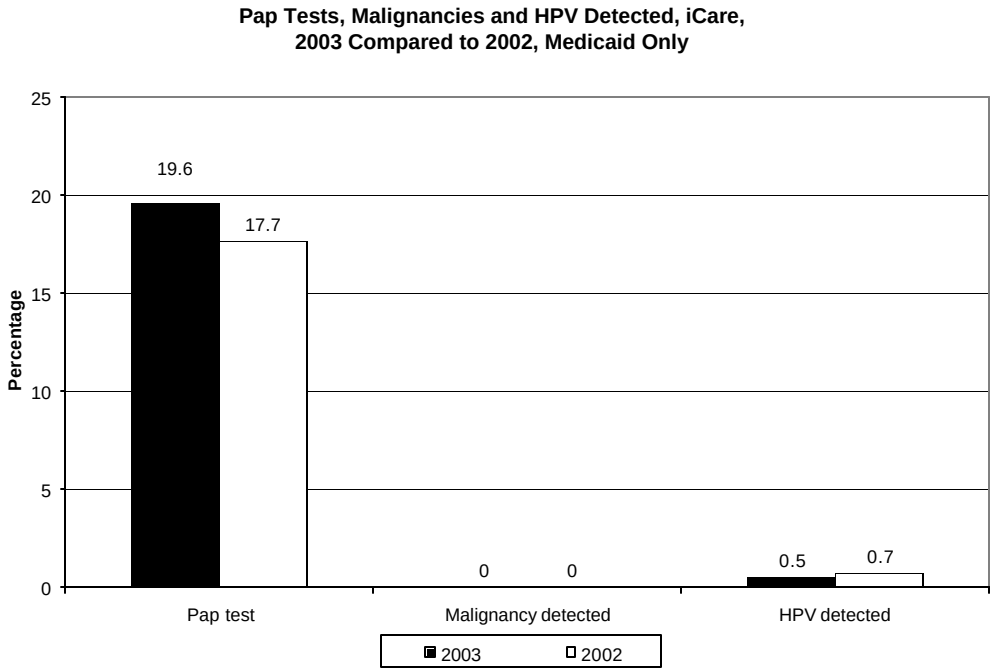
Many mental health and substance abuse conditions can be successfully treated on a day treatment or outpatient basis. Often, people prefer such treatment to inpatient care. Evaluations are tracked using all provider types and outpatient care is tracked by provider type, that is, specialists in mental health or substance abuse and primary care providers (PCP).

The 2003 evaluation rate was 13.2 percent for all ages and provider types, a substantial increase from 2002. The rate for mental health outpatient care provided by specialists increased to 26.6 percent in 2003 from 23.2 percent 2002. The rate for such care by PCPs remained about the same as in 2002 as did the rate of outpatient care for substance abuse by specialists. The rate of substance abuse care provided by PCPs also remained about the same as it was in 2002; just over 1 percent.

This measure tracks provision of evaluations and outpatient care to individuals eligible for Medicaid only.

Pap tests-cervical cancer screening

Monitoring measure



Cervical cancer is diagnosed in approximately 15,000 women in the United States each year. According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women.

Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the measure is designed to take this into account.

The rate of provision of cervical cancer screening tests (Pap tests) increased in 2003 to 19.6 percent from the 2002 rate, which was 17.7 percent. Outcome measure results, the rate of detection of malignancy, for this service was 0.

Human Papillomavirus (HPV) infection is believed to be a causal factor in many cases of cervical cancer. According to the Centers for Disease Control and Prevention (CDC), more than 90 percent of cervical cancers are caused by HPV infections. This measure assesses not only the rate of Pap testing, but also the detection rates for HPV infection. The HPV detection rate was 0.5 percent in 2003, compared to 0.7 percent in 2002.

This measure tracks services for individual eligible for Medicaid only.

For additional information, contact:

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